Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

Ship To: 1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

CHIROPRACTIC EXAMINING BOARD

CERTIFICATE OF COURSE COMPLETION FOR CHIROPRACTIC TECHNICIAN

This form must be completed by the certifying body where your Board-approved course was obtained

APPLICANT: Complete this section and submit to certifying body for completion. Form must be returned directly from the certifying body to the Department at the above address.

Last Name | **First Name** | **MI** | **Former / Maiden Name(s)**

Address: (number, street, city, zip code)

Social Security #: (voluntary-for school's use in locating your records) ☐☐☐ - ☐☐ - ☐☐☐☐

Applicant Signature | **Date** ☐☐/☐☐/☐☐☐☐

CERTIFIYING BODY: Please complete this section and return directly to the Department. You may also fax/email with cover sheet/letter to 608-261-7083 or dspscredchiropractic@wisconsin.gov.

Name of Institution or Provider:

Address of Institution or Provider: (street, city, state, zip)

Sponsor Name:

Course Title:

The above course listed included the following training (check all boxes that apply):

- ☐ **Exercise/Rehabilitation**
- ☐ **Patient History**
- ☐ **Physical Examination** (height, weight and blood pressure specifically)
- ☐ **Physiologic Therapeutics Overview**
- ☐ **Thermotherapy/Cryotherapy**
- ☐ **Mechanical Therapy**
- ☐ **Electrotherapy**
- ☐ **Therapeutic Ultrasound Therapy**
- ☐ **Light Therapy**
- ☐ **Surface EMG**

Dates Attended: From: ☐☐/☐☐/☐☐☐☐ To: ☐☐/☐☐/☐☐☐☐

Date Certificate Issued: ☐☐/☐☐/☐☐☐☐

Signature of Dean or Department Head | **Date** ☐☐/☐☐/☐☐☐☐

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